Montana Department of LABOR & INDUSTRY

BACKGROUND

The content of this document is derived from the expected competencies of various levels of prehospital Emergency Care Providers (ECPs), as outlined in the National EMS Scope of Practice Model 2019: Including Change Notices 1.0 and 2.0 (August 2021). It more specifically reflects the content of the *Interpretive Guidelines*, which are intended to guide users with insight into the discussions, deliberations, and collective opinions of the National Association of State EMS Officials' (NASEMSO) expert panel. The interpretive guidelines allow users to apply a similar methodology in deciding the appropriateness of new interventions at each personnel level but are not all-inclusive. When adapted for use in Montana, the document incorporates content from the Montana Endorsements, as described in Administrative Rules of Montana (ARM) 24.156.2751.

This Montana ECP Scope of Practice document is intended for use as a companion to the National Association of State Emergency Medical Services Officials (NASEMSO) National Model EMS Clinical Guidelines Version 3.0 (March 2022). The Montana Department of Labor and Industry (DLI) licensing staff has adopted the National Model EMS Clinical Guidelines for use by licensed ECPs in Montana. It is the shared responsibility of the Montana ECP and their Medical Director to know, recognize, and operate within their scope of practice.[1] The use of a specific medication or procedures must align with clinical scope of practice, clinical protocols approved by a Medical Director, and the National Model EMS Clinical Guidelines Version 3.0 (March 2022). The Medical Director should be aware of their staff's educational and training history and whether there is a need for additional training to meet the current National Emergency Medical Services (EMS) Education Standards to comply with the Montana ECP Scope of Practice and to meet the training requirements, as listed in the most recent version of the endorsements (2025). The Petition for Exception or Revision to State-approved Practice Guidelines or Educational Curriculum for Emergency Care Providers (ECP) outlines the procedure for the medical director to request an exception.

In the table below, the green shading indicates the skill is within scope of practice at a particular level without an endorsement. The peach shading indicates that an endorsement is required to perform the skill at the level. ECP base levels include Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), and Paramedic.

The DLI licensing staff authorizes the medical director to use the approved Montana ECP Scope of Practice and clinical guidelines in their entirety or they may decide to limit the service or individual ECP practice in accordance with the provider's abilities or needs of the community they serve. However, the local medical director may not alter or expand DLI-approved Montana Scope of Practice without first seeking DLI approval through submission of the Petition for Exception or Revision to State-approved Practice Guidelines or Educational Curriculum for Emergency Care Providers (ECP) as allowed through ARM 24.156.2761.

[1] As described in Administrative Rules of Montana (ARM) 37.104.505 EMS Agency Service Medical Director Duties

CONSIDERATIONS FOR INTERFACILITY TRANSPORT

Emergency Care Providers (ECPs) routinely transfer patients between medical facilities using the knowledge and skills needed to manage the medical needs of the patient. It is the responsibility of the transferring physician, physician assistant (PA), or advanced practice registered nurse (APRN) to ensure the transferring ECP possesses the requisite license and skills to meet a particular patient's needs prior to transport. It is the responsibility of the ECP to recognize when patient care during the requested interfacility transport exceeds their license and skill. The ECP may consult their Service Medical Director and decline transport, if appropriate. The ECP's scope of practice may not be expanded to meet the needs of the patient, but rather the sending facility must ensure adequate continuity of patient care.

CONSIDERATIONS FOR COMMUNITY INTEGRATED HEALTHCARE

ECPs who hold a Community Integrated Healthcare (CIHC) endorsement at their level of licensure and must practice in accordance with ARM 24.156.2753. Communications considerations are included below.

1. If an ECP has a question regarding the patient care plan, they should first call the physician, PA, or APRN who has created the CIHC patient care plan and who requested the assistance of the CIHC-endorsed ECP.
2. If an ECP has questions or concerns about their scope of practice in relation to providing CIHC services, the ECP's Medical Director should be consulted. It is essential that ECPs have regular check-ins with their Medical Directors regarding scope of practice and the duties they are performing.

APPROACH TO USING THIS DOCUMENT

1. Users of the Montana ECP Scope of Practice document are assumed to be a licensed Montana provider and have knowledge of patient management principles found in the National Emergency Medical Services (EMS) Education Standards appropriate to the provider's level of licensure.
2. The Montana ECP Scope of Practice document and the National Model EMS Clinical Guidelines Version 3.0 (March 2022) are not intended to be a sequential approach to patient care where everything must be done in the exact order as written. Montana ECPs are expected to practice medicine at their level of their licensure and as directed by their Medical Director. The licensed provider should always evaluate the needs of the patient on a case-by-case basis. Each level of licensure is expected to appropriately integrate their skills into total patient care.
3. The term "consider" utilized within the National Model EMS Clinical Guidelines Version 3.0 (March 2022) means the ECP should apply critical thinking to determine, within their scope of practice, if that step should be initiated for the best patient outcome and with the optimal risk versus benefit ratio.

4. The Montana ECP Scope of Practice document may be different than the scope of education provided in an ECP training program. It is the shared responsibility of the Montana ECP and their Medical Director to know, recognize, and operate within their scope of practice.
5. It is the shared responsibility of the Medical Director and the ECP to ensure the licensed provider is competent in the skills identified before attempting any procedure or administering any medication contained in this document.
6. Local protocols may allow for flexibility to address local needs but require specific attention by the Medical Director, including use of the Petition for exception or revision to state-approved Practice Guidelines or educational curriculum for Emergency Care Providers (ECP), when necessary. This implies and requires the active participation of the Medical Director to use that section of the protocol. That would include but not be limited to supplemental education, review of recommended dosages and indications for usage, and Quality Assurance/Quality Improvement (QA/QI) review.

SCOPE OF PRACTICE FOR SKILLS BY LEVEL					
SKILLS – AIRWAY/VENTILATION/OXYGENATION					
	EMR	**EMT**	**AEMT**	**Paramedic**	**Endorsement notes**
Airway – oral					
Airway obstruction – dislodgement by manual techniques					
Bag-valve-mask (BVM)					
Head tilt – chin lift					
Jaw thrust					
Mouth-to-barrier, -to-mask, -to-mouth, -to-nose, -to-stoma					
Oxygen therapy – nasal cannula, non-rebreather mask					
Suctioning – upper airway and stoma					
Pulse oximetry					EMR Monitoring Endorsement
Airway – nasal					
Continuous Positive Airway Pressure (CPAP)					
Oxygen therapy – humidifiers, partial rebreather mask, simple face mask, Venturi mask					
Airway – supraglottic					EMT Airway Endorsement
End tidal CO_2 numerical values monitoring					EMT Airway Endorsement
Suctioning – tracheobronchial of an intubated patient					
Chest decompression – needle					AEMT-99 Endorsement
Endotracheal intubation					AEMT-99 Endorsement
Airway obstruction – dislodgement by direct laryngoscopy					
Chest tube placement – assist only					
Chest tube – monitoring and management					
Cricothyrotomy					
Gastric decompression – nasogastric or orogastric tube					
Oxygen therapy – high flow nasal cannula					
End tidal CO_2 interpretation of continuous waveform capnography					
Manage mechanically ventilated patient (includes automatic transport ventilators)					Paramedic Critical Care Endorsement[1]
Drug Assisted Intubation (DAI) or Rapid Sequence Intubation					

[1] Contact online or offline medical director for consultation to modify ventilator settings

SCOPE OF PRACTICE FOR SKILLS BY LEVEL					
SKILLS – CARDIOVASCULAR/CIRCULATION					
	EMR	**EMT**	**AEMT**	**Paramedic**	**Endorsement notes**
Cardiopulmonary resuscitation					
Defibrillation - automated/semi-automated					
Hemorrhage control – direct pressure, tourniquet, wound packing					
Cardiac monitoring and/or 12-lead ECG acquisition and transmission					
Mechanical CPR device					
Telemetric monitoring devices and transmission of clinical data, including video data					
Electrocardiogram interpretation					AEMT-99 Endorsement
Cardioversion – electrical					AEMT-99 Endorsement
Defibrillation – manual					AEMT-99 Endorsement
Transcutaneous pacing					AEMT-99 Endorsement
Transvenous cardiac pacing – monitoring and maintenance					

SCOPE OF PRACTICE FOR SKILLS BY LEVEL					
SKILLS - SPLINTING, SPINAL MOTION RESTRICTIONS, AND PATIENT RESTRAINT					
	EMR	**EMT**	**AEMT**	**Paramedic**	**Endorsement notes**
Cervical collar					
Emergency moves for endangered patients					
Extremity stabilization – manual					
Extremity splinting					
Manual cervical stabilization					
Long spine board					
Mechanical patient restraint					
Pelvic splinting					
Seated Spinal Motion Restriction (SMR), (e.g., Kendrick Extrication Device (KED))					
Splint – traction					

[1] Contact online or offline medical director for consultation to modify ventilator settings
[2] Per National EMS Scope of Practice Model 2019: Including Change Notices 1.0 and 2.0, medical direction should ensure appropriate clinical experience to obtain an acceptable specimen to minimize inaccurate results.

MONTANA EMERGENCY CARE PROVIDER (ECP) SCOPE OF PRACTICE

SCOPE OF PRACTICE FOR SKILLS BY LEVEL					
SKILLS - IV INITIATION/MAINTENANCE FLUIDS					
	EMR	**EMT**	**AEMT**	**Paramedic**	**Endorsement notes**
Intraosseous access – initiation, pediatric or adult					EMT IV/IO Initiation Endorsement
Intravenous access					EMT IV/IO Initiation Endorsement
Intravenous – maintenance of non-medicated IV fluids					EMT IV/IO Initiation Endorsement EMT IV/IO Maintenance Endorsement
Intravenous – maintenance of medicated IV fluids					AEMT-99 Endorsement
Access indwelling catheters and implanted central IV ports (limited to previously used ports)					
Central line – monitoring					

SCOPE OF PRACTICE FOR SKILLS BY LEVEL					
MISCELLANEOUS SKILLS					
	EMR	**EMT**	**AEMT**	**Paramedic**	**Endorsement notes**
Assisted delivery (childbirth)					
Blood pressure automated or manual					
Eye irrigation					
Blood glucose monitoring					EMR Monitoring Endorsement
Assisted complicated delivery (childbirth)					
Patient transport[2]					
Specimen collection via nasal swab[3]					
Venous blood sampling					EMT IV/IO Initiation Endorsement
Blood chemistry analysis					
Eye irrigation – hands free irrigation using sterile eye irrigation device					

[1] Contact online or offline medical director for consultation to modify ventilator settings
[2] DPHHS allows EMR as part of a legal crew as long as at least one crew member is EMT or above.
[3] Per National EMS Scope of Practice Model 2019: Including Change Notices 1.0 and 2.0, medical direction should ensure appropriate clinical experience to obtain an acceptable specimen to minimize inaccurate results.

APPENDIX: MEDICATION LIST FOR MONTANA PROVIDERS

The draft table below reflects the medications referenced in the Montana Endorsements, the National EMS Scope of Practice Model 2019: Including Change Notices 1.0 and 2.0, and the National Model EMS Clinical Guidelines Version 3.0 (March 2022). This is not an exhaustive list of medications that are permissible for Montana Emergency Care Provider (ECP) use. In the table below, not all medication routes are appropriate for every medication listed by name or class on the same line. The administration of specific medications or classes of medications in the table must occur in accordance with the Montana ECP Scope of Practice, clinical protocols approved by a Medical Director, and the National Model EMS Clinical Guidelines Version 3.0 (March 2022). The Petition for Exception or Revision to State-approved Practice Guidelines or Educational Curriculum for Emergency Care Providers (ECP) outlines the procedure for the medical director to request an exception. This is not an exhaustive list of medications that are permissible for Montana Emergency Care Provider (ECP) use.

The Montana Emergency Care Provider (ECP) Scope of Practice *Medication List for Montana Providers* Appendix includes medications listed by Food and Drug Administration (FDA)-approved routes. The rare exception to include an off-label indication occurs when there is historical precedent for including an off-label route of administration and that medication by a specified off-label route is included in the National Model EMS Clinical Guidelines.

1. Visit https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm
2. Search parenthetically listed medications and review FDA-approved routes of administration for inclusion in table. If the table contains a class of medications, then the cross check will occur for the medication referenced by example. If an example is not provided, then the "on-label" routes or general knowledge will apply.
3. The table will include FDA-approved routes unless there is strong historical precedent for listing an off-label route, provided it is also referenced in the National Model EMS Clinical Guidelines (e.g., intraosseous lidocaine).

[1] The use of a specific medication from the medication classes included here must be administered in accordance with Montana ECP Scope of Practice, clinical protocols approved by a Medical Director, and the National Model EMS Clinical Guidelines Version 3.0 (March 2022).
[2] Paramedic may initiate or continue with indication and order from online medical director.
[3] Concurrent use of IM/IV benzodiazepines and olanzapine IM is not recommended as fatalities have been reported, per National Model EMS Clinical Guidelines Version 3.0 (March 2022) page 61.
[4] Immunizations approved by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices, approved by the Medical Director, and in the Montana Endorsement, if applicable.

In the table below, the green shading indicates administration of the medication class by a specific route is within scope of practice without an endorsement. The peach shading indicates that an endorsement is required to administer the medication by a specific route at that level. ECP base levels include Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), and Paramedic. The routes of administration are abbreviated in the table and include, per os (PO), per rectum (PR), intramuscular (IM), intravenous (IV), intraosseous (IO), intranasal (IN), endotracheal tube (ET), inhaled (INH), nebulized (NEB), sublingual (SL), and topical (TOP). Where IV access and drug routing are specified, it is intended to include IO access and drug routing when IV access and drug routing is not possible.

For the purposes of this document, Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS) antiarrhythmic medications are represented as a medication class. It is the shared responsibility of the Montana ECP and their Medical Director to know, recognize, and operate within their scope of practice when using ACLS or PALS algorithms.[1] When the ECP encounters dysrhythmia, they are expected to treat the patient within their scope of practice, according to the most recent prehospital ACLS or PALS protocols, and as directed by their Medical Director.

Emergency Care Providers (ECPs) routinely transfer patients between medical facilities using the knowledge and skills needed to manage the medical needs of the patient. It is the responsibility of the transferring physician, physician assistant, or APRN to ensure the transferring ECP possesses the requisite license and skills to meet a particular patient's needs prior to transport. It is the responsibility of the ECP to recognize when patient care during the requested interfacility transport exceeds their license and skill. The ECP may consult their Service Medical Director and decline transport, if appropriate. The ECP's scope of practice may not be expanded to meet the needs of the patient, but rather the sending facility must ensure adequate continuity of patient care.

[1] The use of a specific medication from the medication classes included here must be administered in accordance with Montana ECP Scope of Practice, clinical protocols approved by a Medical Director, and the National Model EMS Clinical Guidelines Version 3.0 (March 2022).
[2] Paramedic may initiate or continue with indication and order from online medical director.
[3] Concurrent use of IM/IV benzodiazepines and olanzapine IM is not recommended as fatalities have been reported, per National Model EMS Clinical Guidelines Version 3.0 (March 2022) page 61.
[4] Immunizations approved by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices, approved by the Medical Director, and in the Montana Endorsement, if applicable.

MEDICATION BY CLASS					
	EMR	EMT	AEMT	Paramedic	Endorsement notes
Analgesic, non-opioid (e.g., acetaminophen)		PO	PO/IV/IO	PO/PR/IV/IO	
Analgesic, opioid (e.g., morphine sulfate, fentanyl)			IN/IM/IV/IO	IN/IM/IV/IO	AEMT-99 Endorsement[1]
Analgesic, over the counter, for pain or fever		PO	PO	PO	
Anesthetic for intraosseous infusion (e.g., lidocaine)			IO	IO	AEMT-99 Endorsement[1]
Anesthetic, N-methyl-d-aspartate receptor antagonist (e.g., ketamine)				IM/IV/IO	
Anesthetic, N-methyl-d-aspartate receptor antagonist, inhaled (e.g., nitrous oxide)		INH	INH	INH	EMT Medication Endorsement
Antiarrhythmic medications, per the current ACLS and PALS protocols			IV/IO	IV/IO	AEMT-99 Endorsement[1]
Antibiotic continuation during interfacility transport				IV/IO	
Anticholinergic (ipratropium) for dyspnea and wheezing		INH/NEB	INH/NEB	INH/NEB	
Anticoagulant, initiate or continue during interfacility transport (e.g., heparin sodium)[2]				IV	
Antidote for acetaminophen overdose (e.g., acetylcysteine)				PO/IV	
Antidote, auto-injector for chemical/hazardous material exposure (e.g., atropine and pralidoxime autoinjector)	IM	IM	IM	IM	
Antidote for cyanide toxicity (e.g., hydroxocobalamin, sodium thiosulfate)				IV/IO	
Antidote for hypoglycemia (e.g., glucagon)		IM/IN	IN/IM/IV	IN/IM/IV	EMT Medication Endorsement
Antidote for organophosphate poisoning (atropine)			IM/IV/IO/ET	IM/IV/IO	AEMT-99 Endorsement[1]
Antidote (thyroid protective agent) for radiation exposure (e.g., potassium iodide)				PO	
Antiemetics (e.g., ondansetron, prochlorperazine, metoclopramide)			PO/IM/IV/ IO	PO/SL/IM/IV/ IO	
Antifibrinolytic (e.g., tranexamic acid)				IV	
Antihistamine, H1 receptor (diphenhydramine)		PO	PO / IM	PO/IM/IV	EMT Medication Endorsement AEMT Medication Endorsement
Antihistamine, H2 receptor (e.g., cimetidine, famotidine)				PO/IV	
Antipsychotic, atypical (e.g., olanzapine, ziprasidone)[3]				SL/IM	
Antipsychotic, typical (e.g., droperidol, haloperidol)				PO/IM/IV	
Benzodiazepine for anxiolysis or as an anti-convulsant (e.g., diazepam, lorazepam, midazolam)[3]			IN/SL/IM/IV/ IO/PR	IN/SL/IM/ IV/IO/PR	AEMT-99 Endorsement[1]

[1] The use of a specific medication from the medication classes included here must be administered in accordance with Montana ECP Scope of Practice, clinical protocols approved by a Medical Director, and the National Model EMS Clinical Guidelines Version 3.0 (March 2022).
[2] Paramedic may initiate or continue with indication and order from online medical director.
[3] Concurrent use of IM/IV benzodiazepines and olanzapine IM is not recommended as fatalities have been reported, per National Model EMS Clinical Guidelines Version 3.0 (March 2022) page 61.
[4] Immunizations approved by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices, approved by the Medical Director, and in the Montana Endorsement, if applicable.

MEDICATION BY CLASS					
	EMR	EMT	AEMT	Paramedic	Endorsement notes
Beta agonist (e.g., albuterol), patient prescribed supply or supplied and carried by the EMS service		INH/NEB	INH/NEB	INH/NEB	
Beta agonist/bronchodilator and anticholinergic for dyspnea and wheezing		INH	INH	INH	
Blood or blood products				IV	
Calcium salts (e.g., calcium gluconate, calcium chloride)				IV/IO/TOP	
Carbonic anhydrase inhibitor (e.g., acetazolamide)				PO	
Convulsive Antidote for Nerve Agent (CANA) autoinjector			IM	IM	AEMT-99 Endorsement[1]
Cyanide antidote kit				IV	
Dextrose injection 10%			IV/IO	IV/IO	
Electrolytes (e.g., sodium bicarbonate)				IV	
Glucocorticoid (e.g., dexamethasone, methylprednisolone, prednisolone, prednisone, hydrocortisone)		PO/IM	PO/IM | IV/IO	PO/IM/IV/IO	EMT Medication Endorsement AEMT Medication Endorsement
Glucose for suspected hypoglycemia, oral		PO	PO	PO	
Hypnotic, non-barbiturate, for ventilated patient during interfacility transport (e.g., etomidate)				IV	Paramedic Critical Care Endorsement
Immunizations[4]		IM	IM	IM	EMT Medication Endorsement
Immunizations during a public health emergency[4]		IM	IM	IM	
Magnesium salt (e.g., magnesium sulfate)				IV	
Maintain continuous infusions of analgesia for ventilated patients during interfacility transport				IV	Paramedic Critical Care Endorsement
Maintain continuous infusion of sedation for ventilated patients during interfacility transport (e.g., propofol)				IV	Paramedic Critical Care Endorsement
Neuromuscular blocking agent to maintain chemical paralysis during interfacility transport (e.g., atracurium, vecuronium)				IV	Paramedic Critical Care Endorsement
Nonsteroidal anti-inflammatory drug, specifically aspirin, for chest pain of suspected ischemic origin		PO	PO	PO	
Nonsteroidal anti-inflammatory drugs for pain, parenteral (e.g., ibuprofen, ketorolac)			IM/IV	IM/IV	
Opioid antagonist auto-injector for suspected opioid overdose (e.g., naloxone)	IM	IM	IM	IM	
Opioid antagonist for suspected opioid overdose (e.g., naloxone)	IN	IN	IN	IN	
Opioid antagonist (e.g., naloxone), other routes		IM/IV/IO	IM/IV/IO	IM/IV/IO/ET	EMT Medication Endorsement
Over the counter medications, topical				TOP	

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[3] Concurrent use of IM/IV benzodiazepines and olanzapine IM is not recommended as fatalities have been reported, per National Model EMS Clinical Guidelines Version 3.0 (March 2022) page 61.
[4] Immunizations approved by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices, approved by the Medical Director, and in the Montana Endorsement, if applicable.

MEDICATION BY CLASS					
	EMR	EMT	AEMT	Paramedic	Endorsement notes
Skeletal muscle relaxant (succinylcholine) during interfacility transport				IV	Paramedic Critical Care Endorsement
Sympathomimetic auto-injector (e.g., epinephrine), patient prescribed	IM	IM	IM	IM	
Sympathomimetic auto-injector (e.g., epinephrine), supplied and carried by the EMS service		IM	IM	IM	
Sympathomimetic (e.g., epinephrine)		IM	IM/IV/IO	IM/IV/ET/IO	EMT Medication Endorsement (1:1,000 = 1 mg/ml formulation, specifically)
Sympathomimetic, topical (e.g., oxymetazoline)			IN	IN	AEMT-99 Endorsement[1]
Thiamine			IM/IV	IM/IV	
Vasodilator for elevated blood pressure (e.g., hydralazine)				IV	
Vasodilator (nitroglycerin) for chest pain of suspected ischemic origin supplied and carried by the EMS service		SL	SL	SL/IV	EMT Medication Endorsement
Vasodilator (nitroglycerin) for chest pain of suspected ischemic origin, limited to patient's prescribed medication		SL	SL	SL	
Vasopressor (e.g., norepinephrine, dopamine)				IV	

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[2] Paramedic may initiate or continue with indication and order from online medical director.
[3] Concurrent use of IM/IV benzodiazepines and olanzapine IM is not recommended as fatalities have been reported, per National Model EMS Clinical Guidelines Version 3.0 (March 2022) page 61.
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